Grant Award No. **CFDA No.**	North Dakota Department of Health 600 East Boulevard Ave-Dept. 301 Bismarck, ND 58505-0200 **NOTICE OF GRANT AWARD**
Budget Period From: Through:	

Title of Project/Program: **Health Dept. Grant Code:**

Veterinarian Loan Repayment Program

Grantee Name and Address:	**North Dakota Department of Health Program Director:**
Contact Name: Telephone:	Gary Garland Office of Community Assistance 600 E Boulevard Ave Dept 301 Bismarck ND 58505-0200 Telephone: (701) 328-4839

Financial Information	**Health Dept. Share**	**Grantee Share Required**	**Total Project Costs**
Amount of Financial Assistance	$0	$0	$0
Previous Funds Awarded	$0	$0	$0
Total Funds Awarded to Date	$0	$0	$0

All Grant Award payments are processed upon receipt of expenditure reports unless otherwise specified in Special Conditions.

Scope of Service:

The grantee agrees to provide full-time veterinary services for a minimum of ____ years in the community identified in the application as approved by the Health Council; maintain licensure to practice veterinary medicine in North Dakota; and accept Medicaid patients as specified on the application form.

Reporting Requirements:

Special Conditions:

Grantee must have practiced at least six months on full-time basis before any loan repayment may be made.

The loan repayment funds may not be used to satisfy other service obligations under similar programs.

If the grantee breaches the loan repayment program contract by failing to complete an entire year of service, the amount repayable under this contract will be prorated an no further payments will be made.

Any financial obligation of the Department of Health arising out of this loan repayment contract and any obligation of the grantee that is conditioned thereon, is contingent on funds being appropriated by the legislature for loan repayment under North Dakota Century Code Chapter 43-29.1.

Amount to be paid to Lender(s) as follows:	**Amount of Payment(s)**	**Date(s) of Payment(s)**

If the Grantee fails to complete an entire year of service, the amount payable under this contract for that year will be prorated.

Evidence of Grantee's Acceptance		**Evidence of Departmental Acceptance**	
Signature	Date	Signature	Date
Typed Name and Title of Authorized Representative		**Typed Name and Title of Authorized Representative** Arvy Smith, Deputy State Health Officer	
Signature	Date	Signature	Date
Typed Name and Title of Authorized Representative		**Typed Name and Title of Authorized Representative** Gary Garland Health Resources Section	

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